PROGRESS

VOLUME II NUMBER 4 JANUARY, 1961

IN THIS ISSUE

THE ALCOHOLISM FOUNDATION OF ALBERTA

CALGARY CLINIC
737 - 13th Avenue S.W.
Telephone AMherst 9-6101

ADMINISTRATIVE CENTRE
AND EDMONTON CLINIC
9910 - 103rd Street
Telephone GArden 4-7161

The Alcoholism Foundation of Alberta is a private Foundation incorporated in 1951 under the Societies Act, financed by provincial and municipal grants, corporate and private contributions. The Foundation's three point program of Education, Treatment, and Research, is directed at the eventual Prevention of Alcoholism in Alberta. Patient counselling, medical, educational, and research services are provided through the two centres in Edmonton and Calgary. The Foundation recognizes alcoholism as a treatable illness, a serious public health problem, and therefore a public responsibility.

TREATMENT

Treatment services are available to anyone desiring help with a drinking problem. The treatment program includes individual counselling, medical treatment, and group therapy. A service fee of $10.00 is charged to the patient. No patient is ever denied treatment due to inability to pay.

There are no consulting fees.

Edmonton and Calgary out-patient clinic hours — 9 a.m. to 5 p.m.
Monday through Friday.

The Alcoholism Foundation of Alberta

Executive Director - MR. J. GEORGE STRACHAN

PROGRESS

Volume II, Number 4, Edmonton, January, 1961

Editor: T. G. Coffey

PROGRESS is published every two months as part of the Foundation's Educational program in order that a more comprehensive knowledge, greater understanding, and more objective viewpoint of the illness alcoholism be provided the people of this province. All material in PROGRESS is believed to have been obtained from reliable sources, but no representation is made as to the accuracy thereof. Opinions expressed in the articles themselves are not necessarily those of The Alcoholism Foundation of Alberta, but are those of the authors reported.

Requests for permission to reprint articles from PROGRESS are welcomed.

Manuscripts are invited on the understanding that no fees can be paid.

Persons desiring to receive PROGRESS regularly (there is no charge) should write to:

PROGRESS
9910 - 103rd Street
Edmonton, Alberta

With this issue of Progress we begin a new year. This is, therefore, an ideal opportunity to bring to each of you, from all of us of the Foundation, every wish for continued health and happiness and to thank you for your continued interest, support and understanding.
The past year was a most effective and progressive one in which we saw the whole climate of our operation stimulated. We look forward to an even greater new year. May we hope that you have enjoyed this publication and find through this medium of communication materials both informative and interesting. A Happy New Year.

J. GEORGE STRACHAN AND STAFF
The Alcoholism Foundation of Alberta

Comment

Three articles in this issue are about the alcoholic and the professional—the social worker, the clergyman and the doctor.

Herman E. Krimmel is Director of Casework Services and editor of 'News' for the Cleveland Center on Alcoholism. He has kindly given us permission to reprint his interesting paper *Professional Attitudes Toward Alcoholism* which originally appeared in the September-October issue of 'News.'

Mr. Krimmel writes of the importance of professional attitudes. Too many professionals are still not detecting the problem drinker, and when he is detected "there is a hopeless feeling that nothing can be done".

The Doctor and the Alcoholic, discusses the role of the physician. "If significant numbers of alcoholics are to be helped, it is essential that the general health resources of the Community, including the practicing physician, be a part of this effort."

The Clergyman and the Indigent Alcoholic is a reprint of a talk **A. W. Fraser** gave to a group of clergymen from the downtown area in April, 1960. How to help the indigent alcoholic who comes to you for assistance, is a constant problem to clergymen. Mr. Fraser, who is Associate Director, Treatment Services, points out that to give material assistance—a hand-out or meal ticket—may only perpetuate the indigent's problems and postpone a chance of recovery.

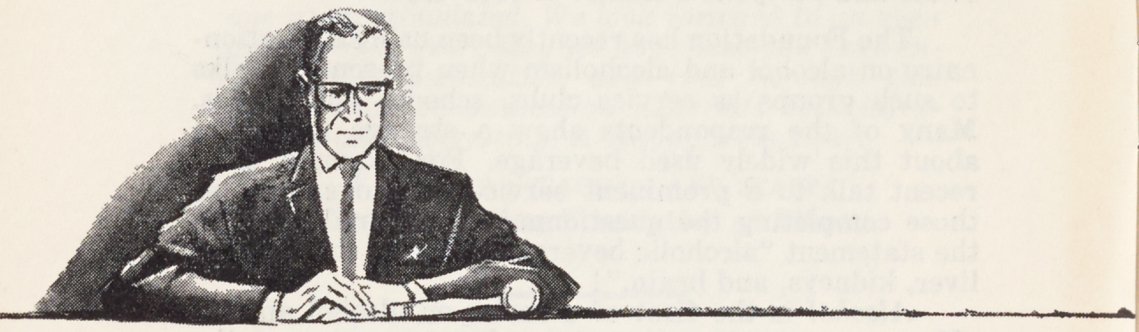
The Foundation has recently been using a questionnaire on alcohol and alcoholism when presenting talks to such groups as service clubs, schools, and nurses. Many of the respondents show a strange ignorance about this widely used beverage. For example, at a recent talk to a prominent service club, over half of those completing the questionnaire answered 'true' to the statement "alcoholic beverages directly damage the liver, kidneys, and brain."!

Alcohol is the first of a series on alcohol and its effect on man—an attempt to clear up some of the popular superstition and misconception that surround alcohol.

As an insert in this first issue of the year is a *Summary of the Year's Activities, 1960.* A more detailed report will be ready in a few weeks and will be available to any interested reader.

CONTENTS

PROFESSIONAL ATTITUDES TOWARD



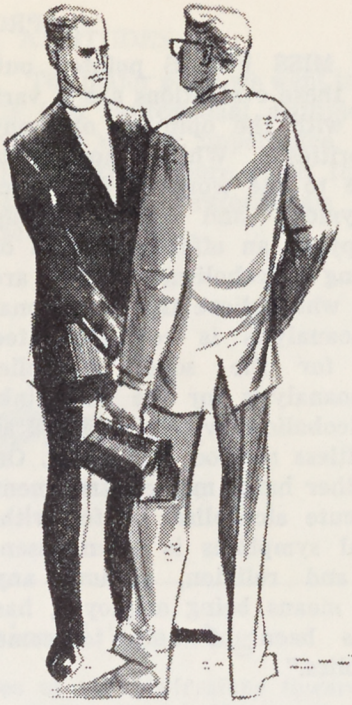
WE HAVE REPEATEDLY emphasized that alcoholics are the responsibility of all professionals working with troubled and confused people. The magnitude of the problem of alcoholism makes this total approach essential if there is to be any real hope for a successful solution.

Some progress has been made. There is still a long way to go. In many social agencies, as well as in the offices of physicians, clergymen, psychologists and personnel managers, drinking problems are not detected or, if they are detected, there is a hopeless feeling that nothing can be done. This failure is not universal by any means, but it is distressingly widespread. Moreover, it is complicated by too many professionals in private practice who dismiss the alcoholic as a poor financial risk or just not worth the trouble. And when overcrowded agencies and clinics have to select those applicants with the most favorable prognosis for treatment, the alcoholic is easily shunted aside.

All this leads, somewhat circuitously, to the importance of professional attitudes toward alcoholics as a help or hindrance in working with them. Research has scarcely touched this vital area. The best we have seen was reported in "A Survey of Social Workers' Attitudes Toward Alcoholism" and was presented at the 1960 National Conference of Social Work by Estelle Fuchs of the Jewish Family Service of New York City.

ALCOHOLISM

by Herman E. Krimmel



One of the most encouraging results of the survey was that those questioned (all qualified practitioners and members of the National Association of Social Workers) almost unanimously rejected such old wives' tales as "alcoholism is inherited" or "most alcoholics come from the lowest social strata" or "alcohol is the only cause of alcoholism" or "alcoholism is due to deficient will power." The vast majority agreed that "alcoholism is a symptom of underlying emotional disturbances" although only about half could accept the statement that "alcoholism is a disease."

Most of the social workers indicated either sympathy or understanding in their "reactions to a stranger who is drunk" (not necessarily synonymous with alcoholism, of course), but there were mixed feelings and many confessed to disgust, fear, annoyance or indifference. Those who had worked with alcoholism or knew alcoholics personally tended to be more positive in their attitudes than those without experience.

The respondents were asked to rate various treatment techniques as good, fair or poor. The program of Alcoholics Anonymous received the largest number of favorable ratings (58%) and was followed in order of descending frequency by group therapy (49%), individual psychotherapy (42.9%), psychoanalysis (32.2%), social casework (22.1%), medical treatment (8.9%) and pastoral counseling (5.6%).

AS MISS FUCHS pointed out, these evaluations are at variance with the opinions of many authorities. While most subscribe to the work of Alcoholics Anonymous and regard group therapy as an effective means of treating alcoholism, there are many who believe that traditional psychoanalysis is contraindicated even for the sober alcoholic. Psychoanalysis for the still-drinking alcoholic is widely regarded as a fruitless method of therapy. On the other hand, medical treatment for acute alcoholism or for withdrawal symptoms is often essential, and religion, without any other means being employed, has always been of help to some alcoholics."

Our own reaction is that the results clearly reflect wide professional as well as public acceptance of the program of Alcoholics Anonymous, but it may also imply a feeling among many that if A.A. doesn't work, nothing will. A similar misconception might be attributed to the many who may feel that psychiatric treatment is indispensable rather than just one of several effective therapy techniques. The low rating of casework may provide some insight into the wariness of many social workers when they are confronted by the alcoholic. We certainly get the impression that far more education of professional people is required.

One of the most interesting results of the survey was that no more than 10% of the respondents considered the prognosis with alcoholics to be favorable with any of the specified treatment methods. We suspect that this attitude is not confined to social workers.

Research to measure success of treatment methods has been so limited that any estimate is only that and nothing more. Even if 30% is accurate, however, it is not reason to be discouraged. Indeed, at this stage of our knowledge and with the limitations on existing facilities, it can be viewed with some pride and considerable hope for the future.

AS MENTIONED BEFORE, this is the only research into the gauging of professional attitudes which has come to our attention. We are inclined to believe, however, that other professions are also groping. A recent workshop in Florida devoted to "Pastoral Care in the Rehabilitation of the Alcoholic" elicited much that was positive and encouraging, but the reports did include comments about "the helplessness that the minister feels when he is handling the alcoholic problem alone" and questions about the readiness of the clergyman "to take his place on a team of specialists."

A few years ago, Dr. Melvin Chertack, a Chicago physician, observed that "the busy practitioner attempts to avoid the alcoholic in his practice . . . Many physicians are less willing to assume the care of the alcoholic who, in comparison with other patients, re-

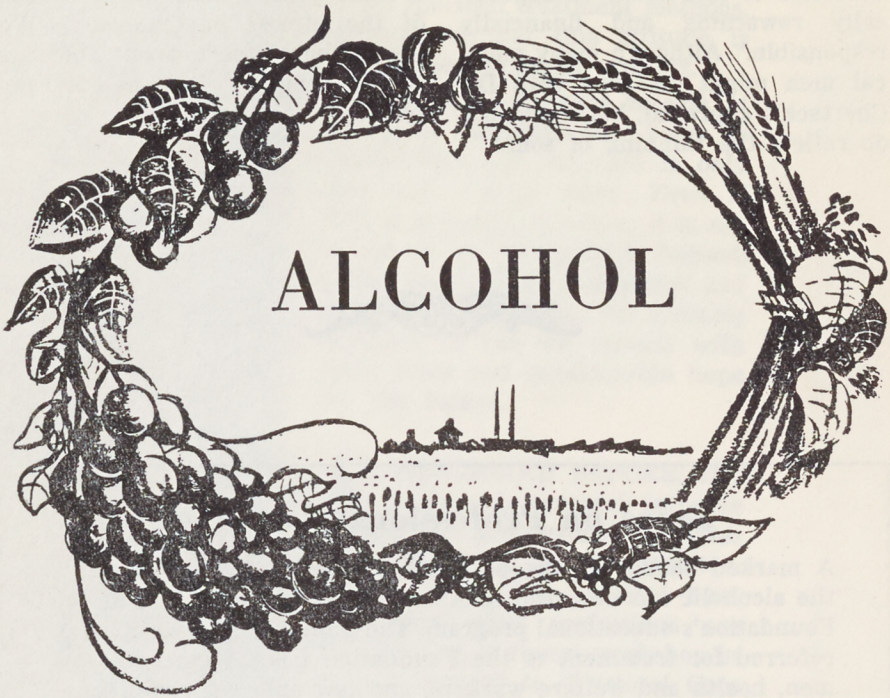
quires more of the doctor's limited time and is less often therapeutically rewarding and financially responsible." Although many medical men might disagree with Dr. Chertack's appraisal, his comments do reflect the thinking of some.

The major point we want to make is that professional attitudes are of the utmost importance. We should know more about them as should the professionals themselves.

Focus on Professional Training

A marked change in the attitudes of the professions towards the alcoholic has occurred in Alberta since the inception of the Foundation's educational program. The number of patients being referred for treatment to the Foundation from doctors, clergymen, health and welfare workers, and law enforcement officers is rising each year. Much of the credit for this improvement must go to the Foundation's educational program.

As an example of this work, in the past year staff of the Foundation have lectured to fourth-year University medical students; met with members of local medical associations; held seminars for clergymen and health and welfare workers; and given courses of lectures for law enforcement officers, nurses, and students of the Faculties of Education and Physical Education at the University.



by T. G. Coffey

Some basic facts on alcohol—manufacture, fermentation, different types of alcoholic beverages, absorption, oxidation, and concentration in the body. Future articles in this series will deal with the psychological, physiological, and social effects of alcohol.

THERE ARE MANY kinds of alcohol — ethyl, methyl, propyl, butyl, and numerous others— all with different chemical formulae, different properties and different uses.

Except for traces of methyl and the higher alcohols, ethyl alcohol is the only alcohol to be found in alcoholic beverages. Pure ethyl alcohol (C_2H_5OH) is a colourless, almost odorless liquid, with a pow-

erful, burning taste. Of all the alcohols, ethyl is the best suited and also the safest for human consumption. It mixes readily with water, it can be concentrated by distillation, and it can be prepared with the greatest of ease from a wide variety of substances that grow over the entire surface of the earth. It is, and always has been, man's intoxicant of choice.

Methyl alcohol, which is often found in rubbing alcohol and other commercial products, is just about as intoxicating as ethyl alcohol, but is burned or oxidized in the body very slowly. The man of average weight who drinks, say, a pint of whisky, after 24 hours will have no alcohol left in his body. But if this same man drank an equivalent amount of methyl alcohol, he would not get rid of it for perhaps a week. It will stay in his body for a long time, so that he not only has a long period of intoxication, but if he drinks more within the week, he will accumulate methyl alcohol in his body. Methyl alcohol, in the process of elimination, is converted into a very poisonous substance that may lead to blindness. It is dangerous and unsuitable as a beverage alcohol.

Process of Fermentation

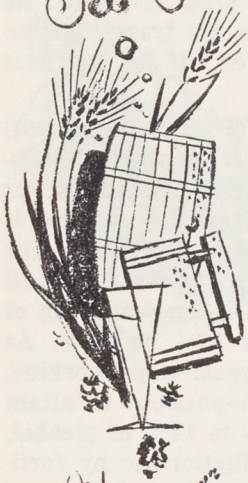
Man discovered alcohol; he did not invent it. The process of fermentation by which alcohol is made has always occurred in nature. Fermentation is the work of a group of one-celled fungi, the yeasts, which are present on the skins of fruit and grain and whose spores float in millions in the air. If fruit juice is left open to the air, these yeasts convert the sugar of the juice into ethyl alcohol and carbon dioxide, a gas which bubbles off. This process of fermentation is exactly the same process that is used in the raising of dough in making bread. The yeast forms alcohol and carbon dioxide which is trapped in the dough and gives the bread its porosity. Except for traces, all the alcohol is driven off by the heat of the baking.

This process of fermentation will continue until it is stopped, artifically by heat or chemicals, or when all the sugar is used up. If there happens to be a very large amount of sugar, fermentation will continue until the concentration of alcohol reaches 12% to 14%. At this point the yeast stops working, so that it is impossible to attain more than 12% to 14% of alcohol, except by distillation or by fortification—that is the addition of alcohol.

Few people drink alcohol in its pure state. They drink alcoholic beverages. Almost every material that will ferment has been used to make alcohol: Among those used in different parts of the world are fruit and vegetable juices, tree saps, mare's milk, and honey. Alcoholic beverages may be grouped under three categories: wine, beer and distilled spirits. The basis for the production of all these is fermentation.

Wine

Wine is fermented fruit juice. To prepare wine it is only necessary to leave a fruit juice containing some sugar exposed to the air in a warm place. The yeasts will work on the sugar and produce alcohol. The resulting beverage is a fruit juice in which part or all of the sugar has been changed to alcohol. It still contains the water, the minerals, the solids, and even some small amounts of the vitamins that were present in the original fruit.



Beer

Beer is malted and fermented cereal. Some or all the starch of cereals is first converted into sugar in the process of malting. Yeast is added, which ferments this sugar to alcohol. The result is a cereal broth containing anywhere from 3% to 6% of alcohol plus many of the solids and minerals of the grain which was used. Usually beer is flavored with hops, which give it its distinctive bitter flavor. Hops help preserve the beer, but have no other chemical action than any other flavoring substance such as chocolate or vanilla.

Distilled Spirits

The large class of beverages called distilled spirits include such beverages as whisky, brandy, rum, vodka, gin. All distilled spirits have a high concentration of alcohol — usually 40% to 50% of alcohol.

The process of distillation is based on the simple fact that alcohol has a lower boiling point than water. If wine or beer are heated to this boiling point, the alcohol will be driven off into a steam, which is convertetd back into a fluid by cooling.

Distilled spirits, unlike wine or beer, contain no solids, minerals, or vitamins. This is a matter of considerable importance in connection with the dietary deficiency diseases often encountered in excessive users of alcohol.

Distilled wine is brandy and distilled cereal mash is whisky. Distillation was probably not discovered until the ninth century A.D. The names given to distilled spirits indicate very well the profound impression that this new beverage made. Brandy was, and still is in France, known as *Eau de Vie* or water of life, and whisky is a corruption of a Celtic phrase which again means water of life. Brandy was believed to be the elixir of life and was claimed to cure all maladies from eczema to indigestion.

The Meaning of "Proof"

Before the invention of the hydrometer and other apparatus for measuring the specific gravity of a liquid, the strength of alcoholic beverages was determined by the "gunpowder test." Gunpowder was saturated with the beverage. If, when lit, the gunpowder burned, this was "proof" that the beverage contained over a certain amount of alcohol. Canada uses the British "proof strength" which indicates the "degree of alcoholic strength possessed by a liquid containing 57% of alcohol by volume at a temperature of 51 degrees Fahrenheit." Thus, a beverage of 100 proof is 57% alcohol. In the United States 100 proof is 50% alcohol.

Alcohol in the Body

After an alcoholic beverage has been swallowed, it remains for a while in the stomach and then passes into the small intestine. While in the stomach up to 20% of the alcohol is absorbed into the blood. After the alcohol has passed from the stomach into the small intestine, the remainder is absorbed rapidly and completely into the blood and the body. Only the alcohol that is absorbed into the blood and reaches the brain exercises any effect.

The passage of the stomach contents into the smaller intestine occurs through a ring of muscles called the pyloric valve. If this valve should close, either through a physiological protective reflex or through a psychological response to some emotional state, the alcohol will remain for some time unabsorbed in the stomach. This spasm of the pyloric valve frequently terminates in vomiting, so that people who regularly develop this spasm usually do not become excessive drinkers.

The presence of food in the stomach delays the absorption and, consequently, the immediate effect of alcohol. Anyone who drinks occasionally has noticed that a single drink before dinner can have quite an apparent effect, while several drinks after you have eaten a big meal appear to have little effect.

Alcohol as a Warming Drink

Alcohol dilates the blood vessels in the skin, giving an impression of warmth to one who takes it. Actually, far from warming, alcohol dissipates what warmth there is in the body by sending a flow of blood to the surface vessels previously contracted by the cold to conserve warmth in the vital organs. St. Bernard dogs sent to rescue snowbound travellers in the Alps would do far better to substitute for their little barrels of brandy, prosaic thermoses of hot coffee.

Some beverages, such as beer, contain solids, which slow down the rate of absorption. Thus the same amount of alcohol consumed as beer has less *immediate* effect than that consumed as whisky. Carbon dioxide may speed up absorption, so that bubbling alcoholic beverages, such as champagne, quickly "go to one's head."

Oxidation

A small portion of the absorbed alcohol is eliminated in the breath, sweat, and urine, but the far greater portion is reduced in the body by the process of oxidation in which the energy of the alcohol is liberated as heat.

Oxidation is started in the liver and is then continued largely in the muscle tissue of the body. The rate of oxidation depends on the liver and varies by individuals. An average man oxidizes about a third of an ounce of alcohol per hour, or 1½ ounces of whisky in 1¾ hours. Black coffee, exercise, hot baths, and other popular methods, do not influence the rate of oxidation, but they may have an indirect effect in that they take time — time for the natural process of oxidation to occur. Coffee can reduce sleepiness, but not intoxication.

Alcohol can provide a rich source of energy in the body. The alcohol in a 1½ ounce shot of whisky liberates about 100 calories, or the equivalent of six teaspoons of sugar, two pats of butter, or 1½ slices of bread. Although alcohol has some of the properties of food, it contains none of the vitamins, proteins, and minerals that are essential for the body. The excessive drinker is always in danger of getting a substantial proportion of his calories from alcohol and so neglects to eat, frequently causing damage to his body from dietary deficiency.

Concentration in the Blood

The loss of alcohol by oxidation is slow but continuous. But the rates at which alcohol is absorbed are highly variable, depending on the amount consumed, the time during which it is drunk, and the state of digestion. When the absorption is more rapid than the oxidation, the amount in the body rises; when all the alcohol has been absorbed, the amount in the body diminishes until finally none is present.

Seventh
Annual

Progress Report

SUMMARY

Period:
January 1, 1960
December 31, 1960

THE ALCOHOLISM
FOUNDATION OF ALBERTA

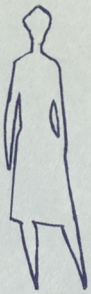
1960

A SUMMARY OF THE

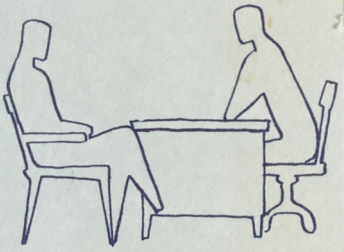
THE ALCOHOLISM FOUN

462 NEW PATIENTS

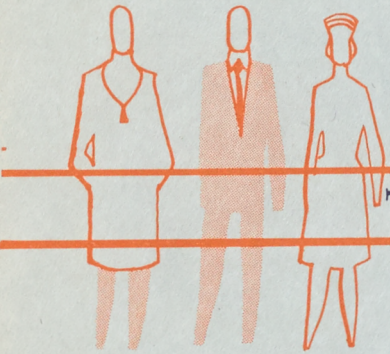
408



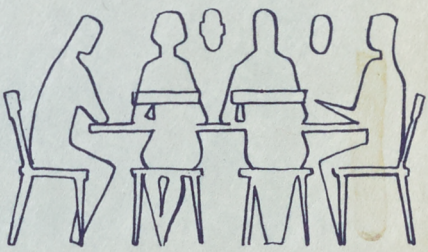
54



7,000 INTERVIEWS



TREATMENT



330 GROUP THERAPY SESSIONS

PROGRESS TRENDS
1953 - 60

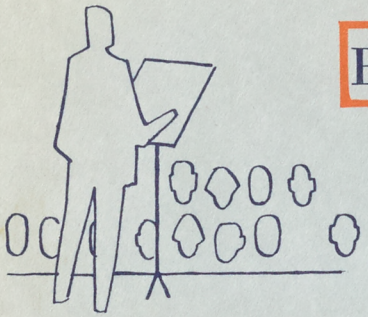
Recovered or Improved
55%

Unimproved
35%

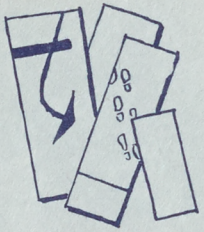
Under Active Treatment
10%

HE YEAR'S ACTIVITIES 1960

OUNDATION OF ALBERTA



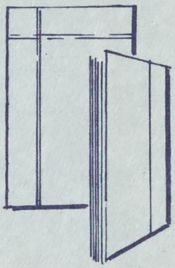
EDUCATION



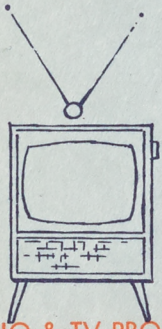
285 PUBLIC TALKS, MEETINGS
AND SEMINARS
11,000 ATTENDANCE

14,280 PIECES OF LITERATURE
DISTRIBUTED

SOCIAL AGENCIES
CHURCHES
DOCTORS
NURSES
INDUSTRY
SCHOOLS
MAGISTRATES
POLICE
GENERAL PUBLIC

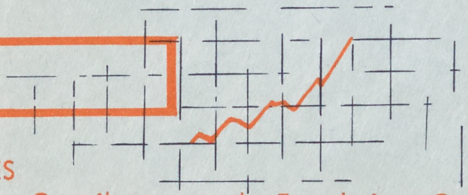


28,600 PERIODICALS
DISTRIBUTED



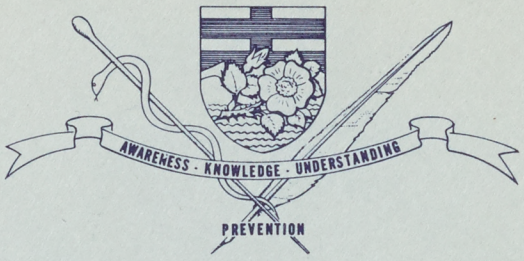
RADIO & TV PROGRAMS

RESEARCH



COMPLETED STUDIES
Follow-up Procedures, Contributions to the Foundation, Group Attendance, Organizational Charts.

CONTINUING STUDIES
Evaluation of Services to Small Communities, Geographic Distribution of Foundation Patients, Drinking Patterns in Alberta, Distribution of Deaths from Cirrhosis.



The Alcoholism Foundation of Alberta is a private Foundation incorporated in 1951 under the Societies Act, financed by provincial and municipal grants, corporate and private contributions. The Foundation's three point program of Education, Treatment, and Research, is directed at the eventual prevention of alcoholism in Alberta. Patient counselling, medical, educational, and research services are provided through the two centres in Edmonton and Calgary. The Foundation recognizes alcoholism as a treatable illness, a serious public health problem, and therefore a public responsibility.

CALGARY CLINIC
737 - 13th Ave. S.W.
Telephone
AMherst 9-6101

ADMINISTRATIVE CENTRE AND EDMONTON CLINIC
9910 - 103rd Street
Telephone
GArden 4-7161

After an alcoholic beverage is swallowed, the alcohol is first diluted in various juices of the stomach and then is absorbed by the blood and the fluid in and about the cells of the tissues of the body. It is distributed uniformly throughout all of the water of the body.

Alcohol may have an irritating effect on the throat and stomach. After it is absorbed, however, it becomes so diluted by the body fluid that it cannot damage the most delicate tissue. The liver damage found in many alcoholics is caused by dietary deficiencies, not by the direct effect of alcohol on the liver.

The extent of the dilution is expressed as the concentration of alcohol in the blood.

The human body is roughly two-thirds water. Thus, a man of 160 pounds would have about 110 pounds or 1,766 ounces of water in his body. If this man drank an ounce of alcohol, that is .079 ounces by weight, the concentration of alcohol in his body would be $0.079 \times \frac{100}{1{,}766}\%$. This comes to about 0.045%. The blood contains proportionately more water, about 85%, so that, after absorption but before oxidation, the concentration of alcohol in this man's blood would be 0.038%.

The larger the man the lower the concentration of alcohol in the blood for any given amount of alcohol in the body. The following table shows the approximate concentration of alcohol in the blood for each ounce of alcohol in the body for men of different weights.

Approximate Concentration of Alcohol in Blood for 1 Fluid ounce of Alcohol in the Body (absorbed but unoxidized).*

Weight lbs.	Concentration of alcohol in blood, per cent.
120	0.050
140	0.043
160	0.038
180	0.033
200	0.030
220	0.028

These figures cannot be taken directly to calculate the concentration that would be developed in the blood from drinking this amount of alcohol. Time would be required for absorption and during this time part of the alcohol would be oxidized. Consequently, all of the alcohol would not be in the body at any one time and the concentration would be lower than that shown in the table.

*From, "What Happens to Alcohol in the Body." Copyright 1941, by Journal of Studies on Alcohol Inc.

ALCOHOLICS ANONYMOUS

— *"Institutional" A.A.*

Prisons

GENERAL SERVICE OFFICE of Alcoholics Anonymous in New York has records of prison groups in all 50 states, the District of Columbia and seven Canadian provinces. Overseas there are 25 groups. Of these, fourteen are located in Australia and New Zealand; the others are in institutions in England, Scotland, Finland, Holland, Northern Rhodesia, The Transvaal, Bermuda and Puerto Rico.

So-called "correctional A.A." had its beginnings at San Quentin Prison, California, under Warden Lewis Duffy in 1941, six years after the movement got under way in Akron, Ohio.

It spread slowly at first; many administrators were skeptical about admitting outside A.A.s to their institutions as visitors or as speakers at meetings.

By 1958, when the Service Office surveyed a national cross-section of administrators, approval of institutional A.A. was virtually unanimous. In a published summary of this study, 55 correctional officials are quoted as endorsing the A.A. program without reservation.

The pattern of A.A. in prisons varies. In some institutions, any inmate who admits that he is an alcoholic can join the group. In others, applicants are screened in an attempt to eliminate the "angle shooters" who may hope to impress parole boards by their affiliation with the movement.

Many groups are carefully organized by the inmates, with duly elected officers, steering committees and publication committees. The publications range from simple mimeographed productions to attractively-printed two- and three-color magazines. Many are circulated widely to other prisons and to interested members "outside." Humor and irony recur frequently in the titles: *The Bottle Stopper, The Insider, Bar-Less, The Brighter Tomorrow, Lost Horizons, Ailin' Alky, Alky Argot* and *On the Wagon.*

A substantial portion of General Service Office staff time is devoted to correctional A.A. Each new prison group receives complimentary literature. Specially-priced literature packages are also available directly to the groups or to

outside sponsors who want to help advance the inmate program.

All correctional groups also receive the monthly A.A. Exchange Bulletin that circulates worldwide. One of the services prized most highly by inmate A.A.s is the annual preparation of a directory of prison groups, coded to show which units can exchange correspondence or tape recordings of A.A. talks. G.S.O. staff members correspond regularly with many prison group secretaries, answering inquiries on A.A. practice and encouraging inmates to become affiliated with an outside group upon release.

IN MOST metropolitan centers, local service offices have created special committees who work closely with groups in prisons and hospitals. These committees schedule outside speakers at prison meetings, share their experience as alcoholics with inmate members and try to help the released man or woman to readjust to society when he or she leaves an institution. Sponsorship of this type is considered one of the crucial phases of A.A. institutional work. In several states it has lead to the formation of large groups of dedicated A.A.'s—many of them former inmates themselves — who voluntarily devote much of their spare time to this work.

Detailed statistical records on correctional A.A. are not available. Reports from administrators, prison chaplains, welfare workers and others seem to indicate, however, that men who join the fellowship as inmates are less likely to be troublesome while they are behind bars, or to violate parole after they leave prison. So far as is known, A.A. members have not been involved in any of the prison disturbances that have made headlines in recent years.

A recent letter to the General Service Office suggests how A.A. was helpful to one inmate alcoholic.

AFTER A LONG drinking history, Mac C. (not his real name) awoke one morning in a Western jail. He thought he had been committed the previous evening. When he tried to arrange his release, he discovered that he had actually been in jail three days, and was scheduled to spend many more days there. During a "blackout" resulting from drinking, he had been apprehended in an act of armed robbery and had received a 19-year sentence.

Mac says that he was a sullen, resentful prisoner the first year. He learned that his wife, who had also drunk irrationally, had joined A.A. shortly after his incarceration, but this made little impression on him.

After he had been in prison about a year, fellow inmates invited him to attend A.A. meetings being conducted in the institution. He did so, largely out of a desire to mingle with the visiting A.A. speakers. Although he was still not

convinced that he was an alcoholic, he began to memorize A.A. principles and referred to them glibly in letters to his wife. She, however, sensed the superficiality of his comments and admonished him to "get honest with himself."

Dismayed, Mac took a second look at the A.A. program and at himself. Reviewing his life, he had to admit that he was, indeed, an alcoholic and that the A.A. program of realistic self-appraisal and mutual helpfulness did make sense. He joined the inmate group.

"I made progress in A.A.," he writes. "The last four years were happy ones, even in prison. My institutional record was perfect, thanks to A.A., and I made more honest and true friends than I had ever known before."

Mac was paroled after six years of his 19-year term. His first outside contact was with the A.A. group in his home town. The members there knew of his prison record "but I was treated as an equal." In a short time he was elected secretary of this group and later was chosen to speak at a statewide A.A. convention. He has been sober now for more than two years.

"Had it not been for A.A. in our prison, with the honest and sincere efforts outside A.A.s gave our group, I would still be there," Mac writes. Today Mac and his wife are both active in institutional A.A., trying to help other alcoholics who are still behind bars.

ONE OF THE paradoxical phases of correctional A.A. is its influence upon "outside" members who work with inmates.

"When I first visited a prison group, I fancied that I was carrying encouragement and inspiration to the poor devils behind bars," one member says. "Instead, I found myself being inspired by the determination and honest self-appraisal of men and women who, although removed from the temptation to drink, are trying to build a solid foundation for their lives tomorrow. When a fellow serving a life term voluntarily joins A.A. because he feels the program can help him be a better person in prison, I begin to appreciate how much more this recovery program can mean to me on the outside."

Hospitals

RECENT estimates show that there are approximately 7,200 recovered alcoholics in about 300 A.A. hospital groups around the world. In the U.S. alone such groups are found in 45 states and the District of Columbia. There are thirteen groups in six Canadian provinces and two groups in Mexico. Of the more than 30 units overseas, nineteen are located in Australia, where both prison and hospital A.A. have taken firm root. There are three hospital groups in Africa (Northern Rhodesia and The Transvaal) and a like number in South America (Chile and Columbia).

Most hospital groups are in tax-supported institutions. In the U.S., for example, these include state hospitals, Veterans Administration facilities and county and municipal hospitals. A relatively high percentage of patient-members are in institutions for those suffering from tuberculosis.

(A.A. itself does not maintain hospitals or convalescent homes. In some areas, individual members have established "homes" or "farms" for alcoholics in which the A.A. program of recovery from alcoholism is an important element of the total therapy. Such facilities are in no way connected with the Fellowship as a whole.)

A.A. hospital groups are usually sponsored by "outside" groups or by institutional committees representing a number of such groups. These sponsors work with hospital administrators in getting new groups under way, provide speakers for meetings within the institutions, make A.A. literature available to members and share their experience as alcoholics with them. The sponsors also encourage patient-members to become affiliated with a local A.A. group upon their release from an institution.

The General Service Office of A.A. corresponds with hospital group secretaries on matters of traditional A.A. procedure, issues an annual directory of hospital units and prepares and distributes literature used by the groups.

SINCE THE FOUNDING of A.A. in 1935, hospital administrators' attitudes toward alcoholic patients appear to have changed appreciably. Formerly, many officials were less than enthusiastic about the prospects of rehabilitating alcoholic patients. Today there seems to be increasing acceptance of the theory that alcoholism is an illness that, like diabetes, can be arrested if the alcoholic will accept the fact of his condition and adjust his way of life accordingly. In A.A. this adjustment means abstaining completely from alcohol, with the help and encouragement of other alcoholics who have already achieved sobriety.

This is one of a series of articles relative to the fellowship of Alcoholics Anonymous, as prepared and released by General Service Office of Alcoholics Anonymous.

PASTORAL

The Clergyman and the Indigent Alcoholic

by A. W. Fraser

The following is part of a talk given to a group of downtown clergymen in April, 1960.

The alcoholics you are called upon to deal with can be divided roughly into two groups: the indigent and the non-indigent. These groups present two quite different situations and require different *initial* approaches.

By the non-indigent I refer to those alcoholics who are members of your congregation or church community. They resemble the description given you earlier of the average Canadian problem drinker. They have many problems and serious ones, but they still have a home, are maintaining their families and go to work more or less regularly.

By the indigent I mean those alcoholics who come to you in a destitute condition and whose request is usually for immediate material assistance.

I am going to deal now with the second group; those alcoholics who are chronically or frequently out of work and money, or those who are transients, moving from job to job, from locality to locality and, as often as not, are in between jobs.

First, I wish to make one definite suggestion regarding your immediate response when you are approached for welfare assistance by an alcoholic who is in an obviously inebriated condition. Receive him civilly, and if possible privately, listen to his request and tell him firmly that you follow a definite principle of not giving welfare to a person whom you believe is intoxicated. Then tell him that you hope he will come back as soon as he is sober so that you can help him. If he is not too drunk point out where he might apply for the kind of material help he needs. This, I feel, is the only constructive approach to the inebriated alcoholic. In this way you encourage him toward sobriety, whereas a quick handout at such times will, in all probability, only encourage further drinking. If such an alcoholic is alarmingly sick or helplessly drunk, you may have to take protective action: arrange for

his admission to an Emergency Ward or call the police.

If you are approached for material assistance by someone who is not intoxicated, your position is less clearly defined, especially if you do not know him. Alcoholism is not, by any means, the sole cause of either chronic or temporary indigence. The basic situation in cases like these is that you are faced by a fellow human being who is in trouble; you are being asked to help him out of that trouble in a **specific** way which **he** has chosen.

Anyone who is in the general field of social service, whether he is a clergyman, a social worker, a doctor, a psychologist, or welfare worker, is faced frequently with these situations. We all have to follow the same general principles in our initial approach. Namely, we cannot give a distressed person intelligent, constructive help with a problem until we have some knowledge of how and why that problem arose. Until we have determined this, it is always unwise, and often harmful, to furnish the kind of immediate help that is being requested by the distressed person.

For example, if a doctor immediately grants a patient's request for 292's or a sedative to relieve some kind of distress, with no effort to determine or to treat the underlying cause of the distress, he does nothing but provide immediate relief of pain. The doctor will, therefore, soon be faced with a second and then a third request for the pain-killer. The patient is not being intelligently helped and we realize that he may at the same time be seriously harmed as the untreated basic problem may become more and more pronounced.

Similarly, when you are requested for specific help, it is your obligation to the troubled person to determine the following:

1. The background circumstances of the immediate problem.
   (a) How did it develop?
   (b) Has it occurred previously and if so how frequently?
   (c) How did the man deal with it previously?
   (d) What were the results of his previous way of handling it?
2. Whether he is asking for help with his basic problem or for relief from one of its side effects.
3. Whether providing relief from the side effects may help the person toward resolving the basic problem or whether it may delay this by relieving him of the anxiety and distress which might otherwise motivate him to face and do something constructive about the basic problem.
4. What can **he** do (not what **you** can do) to resolve his immediate and basic difficulties, and how you can guide him into doing this.

As I mentioned, these steps apply to all problems with which we are presented. Let us suppose that after carrying out step 1. you feel that the basic problem in this

case is alcoholism—what do you do?

First remember this. In most cases indigency will *not be a new or particularly frightening situation for this alcoholic.* He is not reacting to indigence the way you would if you were in a similar situation. In all probability he has gone through this a good number of times before and has developed a certain general technique or method of handling it. There are many levels and variations of this method, but basically it amounts to getting someone else to look after him and to resolve his immediate difficulties. This alcoholic's major concentration is on his immediate problems and he shows little awareness or concern for the underlying difficulty — alcoholism. He has become quite adroit in getting the kind of help he wants; he has been unwittingly helped and encouraged in this by those who have extended assistance to him. As long as he is reasonably successful in pursuing this method, i.e. getting others to resolve the difficulties created by his drinking, he will continue to use it, and therefore to go downhill. You must remember that despite many previous handouts, sometimes ranging from hundreds of dollars in the early stages of alcoholism to a dollar or two in the late stages, he has not been effectively helped by these handouts or he would not be at your door now.

You can help him most by trying to break, or at least to interrupt, this habitual pattern. Don't reinforce it by an easy handout. Try to get him to do something *to help himself* out of his immediate predicament. You can:

Steer him to community resources where he himself can apply for the help he needs.

Steer him to casual employment.

Talk to him about the repetitive pattern of his difficulties, the nature and proper treatment of his illness and how his problems can be permanently, not just temporarily, resolved this time by tackling his basic problem — alcoholism.

Encourage him to come back the next day to see you — sober.

Steer him to an alcoholism clinic, or if one is not available, to A.A. (for therapy, not for a handout).

If in exceptional cases you do arrange for him to receive immediate material assistance, you should:

1. Be sure he has an appointment to see you the next day.
2. Arrange only short term, that is, day to day, assistance. Avoid, if at all possible, giving money directly to him.
3. If he starts drinking, cut off assistance immediately and explain to him why you have done this.

Finally, be prepared for a small percentage of positive responses to this approach. Perhaps not too many will come back, but even if they don't, you know that you have given of your time and of your

concern. This is of more value to the individual eventually than giving him money. You will have helped him a little. However, if you give him a quick handout with no follow-up, you have in all probability only encouraged him to pursue his habitual patterns of behavior. What you really have done is just made yourself feel easier and more comfortable by providing quick, concrete, temporary aid of a kind.

If he responds positively to your initial approach, then in your follow-up interviews your approach to him may follow the general principles, outlined to you earlier today when we discussed "Counselling the Alcoholic."[1]

REFERENCE
1. Fraser, A.W.—Counselling the alcoholic. Progress, Vol. 1, No. 3, 46-48, Dec. 1959.

Yale Summer School

The nineteenth Summer School of Alcohol Studies will be held at Yale University from June 25th, 1961 to July 20th, 1961.

Included are: Lectures by specialists drawn from the social sciences, medicine and psychiatry, religion, education and public health; Workshops for physicians, case workers, psychologists, clergy, nurses, educators, probation, parole and correctional officers, personnel directors and supervisors in industry, community leaders.

Enrollment is limited to 300 students.

For a prospectus describing the course, information concerning admission and academic credit, write to: The Registrar, Yale Summer School of Alcohol Studies, 52 Hillhouse Avenue, Yale Station, New Haven, Conn., U.S.A.

This Summer School will be of particular interest to all those interested in alcohol studies since it will be the last to be held at Yale. When a new setting has been found, the Center of Alcohol Studies and Laboratory of Applied Biodynamics are moving from Yale.

MEDICAL

The Doctor and The Alcoholic

Medical interest in addictive drinking has existed over many centuries. But until recently alcoholism was considered by and large to be a moral problem—a failure of self-discipline. If the inebriate became too conspicuous a nuisance, he was taken into the custody of punitive rather than medical authorities.

As long as people could reason that the alcoholic was personally to blame for his own predicament, they felt justified in avoiding any involvement. Even self-righteous feelings of hostility were excusable. The fact that the majority of physicians, too, shared these negative public attitudes prolonged the era of unenlightened ostracism of problem drinkers.

"In some respects," writes R. Straus (University of Kentucky Medical Center), "the redefinition of alcoholism as a form of illness, a public-health and medical problem, has gained more rapid and complete acceptance among the general public and alcoholics themselves than among some members of the medical profession. . . . Most of the physicians who report that they treat alcoholics do so in a limited way and with considerable reservation."

There are many factors which, in combination, help to explain this reluctance where it exists. Alcoholism does not fit neatly into the traditional categories of disease. Its redefinition as an illness actually over-simplifies the complex nature of the problem. As Straus points out, alcoholism "presents no well-defined diagnostic or therapeutic picture; there is no common etiology, no consistently characteristic course, no accepted method of management." Besides its physiological manifestations, there are also important psychological and social aspects to be dealt with. These the general practitioner has quite naturally considered to be outside his sphere of competence. Yet treatment of the medical symptoms alone is usually fruitless: the patient can be physically rehabilitated but is almost certain to relapse. To carry out full-scale re-

habilitation, however, requires more time and specialized knowledge than the average physician has at his command.

Then, too, alcoholic patients present other conflicts for the physician. They often seem uncooperative, unappreciative, disinclined to follow through with the treatment prescribed. They are more likely than others to break appointments, drop out of sight altogether, and not pay their bills. They may be exceptionally demanding. Their episodes of intoxication can cause unique and painful problems for the doctor. Although he understands that all these traits are part of the disease, emotionally he may find it hard to maintain professional objectivity, well-nigh impossible to establish rapport: It may even happen that the alcoholic stirs up conflict in the physician's private feelings about drinking, for virtually no one who has grown up in the United States or Canada during the last century is wholly free of bias on the "liquor issue."

Especially distressing is the circumstance that often the physician is faced with the very practical dilemma of not knowing just how to help his alcoholic patients. His efforts to provide palliative relief bring no real solution and this causes a feeling of discouragement within the profession. Surveys have disclosed the attitude, in some practitioners, that unless one treats alcoholics exclusively they are only a nuisance because of the time required and the unsatisfactory results obtained. One physician put it this way: "The problem drinkers create special problems for the doctor. Special provisions should be made to treat them."

It will be a long wait, however, until the supply of specialized personnel can meet the demand. Meanwhile, Straus emphasizes, "If significant numbers of alcoholics are to be helped, it is essential that the general health resources of the community, including the practicing physicians, be a part of this effort." The situation, he believes, is not as discouraging as it may seem. There are at least three specific signs which point to an improved relationship between the alcoholic and the doctor.

The first of these stems from the current trend in medical education away from the traditional compartmentalization, which stressed separate and distinct diseases, and toward a more comprehensive multi-disciplinary outlook. It is now being taught that human adaptation to illness is not restricted to the individual's body but includes factors in his personality, his social group relations, his customs and beliefs, and the physical environment in which he lives. With the philosophy of comprehensive medicine, alcoholism takes on new interest; with the focus on the whole man, the alcoholic becomes "an ideal vehicle for demonstrating the inter-relatedness of problems in health and disease."

Finally, there is the emergence of the health team approach to medical care, in which groups of medical and other specialists combine their skills. In the field of alcoholism preeminently this type of set-up offers special advantages, and is increasingly practiced.

Together, these new developments enable the physician to entertain a more positive attitude toward the alcoholic as a patient. Straus suggests that this attitude will become general "when, with continuing research, the physician can feel more hopeful and confident of helping the alcoholic; when through health-team organization he can supplement his skills with persons trained to deal with psychological and social ramifications of the problem; and when his philosophy of medicine enables him to define alcoholism as an interesting and medically respectable problem."

REFERENCE

STRAUS, R. Medical practice and the alcoholic. Ann. Amer. Acad. polit. soc. Sci. 315: 117-124, 1958.

OTHER FOUNDATION SERVICES

- **ADVISORY SERVICES:**

  Professional advice and assistance on the problems of alcoholism.

- **AUDIO-VISUAL AIDS:**

  Films, tapes, records, and displays are available on loan.

- **CONFERENCES and SEMINARS:**

  To create a better understanding of the problems of alcoholism and methods of dealing with those problems.

- **INDUSTRIAL WORKSHOPS:**

  For the education of management, supervisory staffs, and general employees in Alberta industry.

- **ORIENTATION PROGRAMS:**

  For nurses, doctors, internes, penal officials, personnel managers, social workers, clergymen, teachers, and other groups.

- **PUBLICATIONS:**

  Progress, News Review, Digest on Alcohol Studies, and original brochures and pamphlets.

- **REFERENCE LIBRARY:**

  Books, pamphlets, and publications by authorities in the field of alcoholism.

- **SPEAKERS' BUREAU:**

  For professional, industrial, church, social, school, civic, and other groups requesting information.

The illustrations in Progress are by Harry Heine

COMMERCIAL PRINTERS LTD., EDMONTON

THE ALCOHOLISM FOUNDATION OF ALBERTA
9910 - 103 STREET, EDMONTON, ALBERTA

CANADA
POSTAGE PAID
PORT PAYÉ
2 c.
PERMIT NO. 719
EDMONTON